



May 2015

# MEDICAID

## Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls

Accessible Version

# GAO Highlights

Highlights of [GAO-15-313](#), a report to congressional requesters

## Why GAO Did This Study

Medicaid is a significant expenditure for the federal government and the states, with total federal outlays of \$310 billion in fiscal year 2014. CMS reported an estimated \$17.5 billion in potentially improper payments for the Medicaid program in 2014.

GAO was asked to review beneficiary and provider enrollment-integrity efforts at selected states. This report (1) identifies and analyzes indicators of improper or potentially fraudulent payments in fiscal year 2011, and (2) examines the extent to which federal and state oversight policies, controls, and processes are in place to prevent and detect fraud and abuse in determining eligibility.

GAO analyzed Medicaid claims paid in fiscal year 2011, the most-recent reliable data available, for four states: Arizona, Florida, Michigan, and New Jersey. These states were chosen because they were among those with the highest Medicaid enrollment; the results are not generalizable to all states. GAO performed data matching with various databases to identify indicators of potential fraud, reviewed CMS and state Medicaid program-integrity policies, and interviewed CMS and state officials performing oversight functions.

## What GAO Recommends

GAO recommends that CMS issue guidance for screening deceased beneficiaries and supply more-complete data for screening Medicaid providers. The agency concurred with both of the recommendations and stated it would provide state-specific guidance to address them.

View [GAO-15-313](#). For more information, contact Seto J. Bagdoyan at (202) 512-6722 or [bagdoyans@gao.gov](mailto:bagdoyans@gao.gov).

May 2015

## MEDICAID

### Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls

## What GAO Found

GAO found thousands of Medicaid beneficiaries and hundreds of providers involved in potential improper or fraudulent payments during fiscal year 2011—the most-recent year for which reliable data were available in four selected states: Arizona, Florida, Michigan, and New Jersey. These states had about 9.2 million beneficiaries and accounted for 13 percent of all fiscal year 2011 Medicaid payments. Specifically:

- About 8,600 beneficiaries had payments made on their behalf concurrently by two or more of GAO's selected states totaling at least \$18.3 million.
- The identities of about 200 deceased beneficiaries received about \$9.6 million in Medicaid benefits subsequent to the beneficiary's death.
- About 50 providers were excluded from federal health-care programs, including Medicaid, for a variety of reasons that include patient abuse or neglect, fraud, theft, bribery, or tax evasion.

Since 2011, the Centers for Medicare & Medicaid Services (CMS) has taken regulatory steps to make the Medicaid enrollment process more rigorous and data-driven; however, gaps in beneficiary-eligibility verification guidance and data sharing continue to exist. These gaps include the following:

- In October 2013, CMS required states to use electronic data maintained by the federal government in its Data Services Hub (hub) to verify beneficiary eligibility. According to CMS, the hub can verify key application information, including state residency, incarceration status, and immigration status. However, additional guidance from CMS to states might further enhance program-integrity efforts beyond using the hub. Specifically, CMS regulations do not require states to periodically review Medicaid beneficiary files for deceased individuals more frequently than annually, nor specify whether states should consider using the more-comprehensive Social Security Administration Death Master File in conjunction with state-reported death data when doing so. As a result, states may not be able to detect individuals that have moved to and died in other states, or prevent the payment of potentially fraudulent benefits to individuals using these identities.
- In 2011, CMS issued regulations to strengthen Medicaid provider-enrollment screening. For example, CMS now requires states to screen providers and suppliers to ensure they have active licenses in the state where they provide Medicaid services. CMS's regulations also allow states to use Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS)—to screen Medicaid providers so that duplication of effort is reduced. In April 2012, CMS gave each state manual access to certain information in PECOS. However, none of the four states GAO interviewed used PECOS to screen all Medicaid providers because of the manual process. In October 2013, CMS began providing interested states access to a monthly file containing basic enrollment information that could be used for automated screening, but CMS has not provided full access to all PECOS information, such as ownership information, that states report are needed to effectively and efficiently process Medicaid provider applications.

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## **Abbreviations**

AHCCCS	Arizona Health Care Cost Containment System
CMRA	Commercial Mail Receiving Agency

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CMS	Centers for Medicare & Medicaid Services
DMF	Death Master File
EPLS	Excluded Parties List System
FSMB	Federation of State Medical Boards
GSA	General Services Administration
HHS	Department of Health and Human Services
hub	Data Services Hub
LEIE	List of Excluded Individuals and Entities
MCO	managed-care organization
MMIS	Medicaid Management Information System
MSIS	Medicaid Statistical Information System
OIG	Office of Inspector General
PARIS	Public Assistance Reporting Information System
PECOS	Provider Enrollment, Chain and Ownership System
PPACA	Patient Protection and Affordable Care Act
SAM	System for Award Management
SSA	Social Security Administration
SSN	Social Security number
USPS	United States Postal Service

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May 14, 2015

The Honorable Fred Upton  
Chairman  
Committee on Energy and Commerce  
House of Representatives

The Honorable Tim Murphy  
Chairman  
Subcommittee on Oversight and Investigations  
Committee on Energy and Commerce  
House of Representatives

Medicaid, a federal–state health-financing program for low-income and medically needy individuals, is a significant expenditure for the federal government and the states, with total federal outlays of \$310 billion in fiscal year 2014. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is responsible for broad program oversight, including disbursement of federal matching funds, while states are responsible for the daily administration of their Medicaid programs. CMS also provides guidelines, technical assistance, and periodic assessments of state Medicaid programs. Federal laws require both federal and state entities to protect the Medicaid program from fraud, waste, and abuse. In February 2015, we reported that Medicaid remains at high risk because of concerns about the adequacy of fiscal oversight of the program, including improper payments to Medicaid providers.<sup>1</sup> In fiscal year 2014, CMS reported an estimated improper-payment rate of 6.7 percent, or \$17.5 billion, for the

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<sup>1</sup>GAO has designated Medicaid as a high-risk program since 2003.

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Medicaid program, which is an increase over its 2013 estimate of 5.8 percent, or \$14.4 billion.<sup>2</sup>

Because of the substantial Medicaid program expenditures and the program's significant estimated improper-payment rate, you asked us to review the program-integrity efforts associated with beneficiary-eligibility determination and provider enrollment in selected states. Specifically, for this review we

(1) identified and analyzed indicators, if any, of improper or potentially fraudulent payments to Medicaid beneficiaries and providers; and

(2) examined the extent to which federal and state oversight policies, controls, and processes are in place to prevent and detect fraud and abuse in determining eligibility for Medicaid beneficiaries and enrolling providers.

To identify indicators of potentially improper or fraudulent payments to Medicaid beneficiaries and providers, we obtained and analyzed Medicaid claims paid in fiscal year 2011, the most-recent consistently comparable data, for four states: Arizona, Florida, Michigan, and New Jersey. Medicaid payments to these states constituted about 13 percent of all Medicaid payments made during fiscal year 2011. These states were selected primarily because they had reliable data and were among states with the highest Medicaid enrollment. The results of our analysis of these states cannot be generalized to other states. We obtained CMS Medicaid Statistical Information System (MSIS) beneficiary, provider, and other services claims data, as well as state Medicaid Management Information System (MMIS) claims identification data to perform our work.

We performed data matching to identify indicators of potentially improper payments, which includes fraud. These matches sought to identify individuals who may be ineligible to receive Medicaid benefits or

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<sup>2</sup>An improper payment is defined by statute as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. Fraud is one type of improper payment and involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Not all improper payments are a result of fraud. Additionally, Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation was found.

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providers who should not have received Medicaid payments due to residency, death, or other exclusionary factors. We used the beneficiary files to identify individuals who had payments made on their behalf concurrently by two or more of our selected states. To identify potentially improper payments, we compared the beneficiary and provider identity information shown in the Medicaid claims data to the Social Security Administration's (SSA) full Death Master File (DMF) to determine whether any beneficiaries were deceased.<sup>3</sup> We also compared beneficiaries' identity information from the four selected states to the identity information from SSA official records using the Enumeration Verification System. This comparison helped identify individuals who submitted potentially invalid or inappropriate identity information on their Medicaid beneficiary applications. However, many applications may have inaccuracies due to simple errors such as inaccurate data entry or incomplete sections, making it impossible to determine whether these cases involve potential fraud.

To identify claims that might have been improperly processed and paid by the Medicaid program because the federal government had excluded the corresponding providers from providing services to Medicaid beneficiaries, we compared the Medicaid claims to the exclusion and debarment files from HHS's Office of Inspector General (OIG) and the General Services Administration (GSA). To identify claims that might have been improperly paid to providers with invalid licenses, we compared Medicaid claims data to Federation of State Medical Boards (FSMB) license data for providers that had licenses that were revoked or suspended.

To identify claims that might have been improperly processed and paid by the Medicaid program because either the providers or beneficiaries were incarcerated, we compared the Medicaid claims to data files listing incarcerated individuals from the four selected states. To identify claims that are associated with inaccurate, missing, or invalid addresses, we used the United States Postal Service (USPS) Address Matching System

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<sup>3</sup>SSA maintains death data—including names, Social Security numbers (SSN), date of birth, and states of death—in the Death Master File (DMF) for approximately 98 million deceased individuals. The more-comprehensive file, which we refer to as the "full DMF," is available to certain eligible entities and includes state-reported death data. A subset of the full DMF, which we call the "public DMF," is available to the public and does not include state-reported death data.

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Application Programming Interface.<sup>4</sup> As discussed later in this report, managed-care organizations (MCO) receive a monthly capitated payment.<sup>5</sup> As a result, the Medicaid paid amounts associated with managed care reflect these capitated payments and not the costs of specific services provided to a beneficiary. Consequently, our estimate may understate the actual cost of the Medicaid services provided. All of the states included in our review—Arizona, Florida, Michigan, and New Jersey—had some MCO arrangements in place.

To identify federal and state oversight policies, controls, and processes to prevent and detect fraud and abuse in the enrollment of Medicaid beneficiaries and providers, we reviewed federal statutes, CMS regulations, and state Medicaid policies pertinent to program-integrity structures, met with agency officials, and visited state Medicaid offices that perform oversight functions. We used federal standards for internal control,<sup>6</sup> GAO's Fraud Prevention Framework,<sup>7</sup> federal statutes and Medicaid eligibility regulations<sup>8</sup> to evaluate these functions.

To determine the reliability of the data used in our analysis, we performed electronic testing to determine the validity of specific data elements in the federal and selected states' databases that we used to perform our work. We also interviewed officials responsible for their respective databases and reviewed documentation related to the databases and literature related to the quality of the data. On the basis of our discussions with agency officials and our own testing, we concluded that the data elements used for this report were sufficiently reliable for our purposes.

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<sup>4</sup>For the purposes of our report, we will refer to this as the USPS address-management tool.

<sup>5</sup>Under managed-care arrangements, states contract with MCOs to deliver care through networks. States typically pay the MCOs a fixed amount each month, called a capitation payment. Approximately 70 percent of Medicaid enrollees are served through managed-care delivery systems, in which providers are paid at a monthly capitation payment rate.

<sup>6</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21](#).3.1 (Washington, D.C.: November 1999).

<sup>7</sup>GAO, *Individual Disaster Assistance Programs: Framework for Fraud Prevention, Detection, and Prosecution*, [GAO-06-954T](#) (Washington, D.C.: July 12, 2006).

<sup>8</sup>Title XIX of the Social Security Act and Title 42, Parts 430–456, of the Code of Federal Regulations.

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We conducted this performance audit from March 2014 to May 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our audit findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. More details on our objectives, scope, and methodology can be found in appendix I.

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## Background

Medicaid was established in 1965 by Title XIX of the Social Security Act as a joint federal–state program to finance health care for certain low-income, aged, or disabled individuals.<sup>9</sup> Medicaid is an entitlement program, under which the federal government pays its share of expenditures for any necessary, covered service for eligible individuals under each state’s federally approved Medicaid plan, as described below. States pay qualified health-care providers for covered services provided to eligible beneficiaries and then seek reimbursement for the federal share of those payments.

Title XIX of the Social Security Act allows flexibility in the states’ Medicaid plans. Although the federal government establishes broad federal requirements for the Medicaid program, states can elect to cover a range of optional populations and benefits. Guidelines established by federal statutes, regulations, and policies allow each state some flexibility to (1) broaden eligibility standards; (2) determine the type, amount, duration, and scope of services; (3) set the rate of payment for services; and (4) administer its own program, including processing and monitoring of medical claims and payment of claims. Differences in program design can lead to differences in state programs’ vulnerabilities to improper payments and state approaches to protecting the program. States are required to submit plans to CMS to outline their plans to verify Medicaid eligibility factors, including income, residency, age, Social Security numbers (SSN), citizenship, and household composition. With more than 50 distinct state-based programs that are partially federally financed, overseeing Medicaid is a complex challenge for CMS and states.<sup>10</sup>

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<sup>9</sup>42 U.S.C. § 1396a et seq.

<sup>10</sup>In addition to the 50 states, the District of Columbia, Guam, and other U.S. territories have Medicaid programs in place.

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In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory-eligibility groups) and gives the states the flexibility to cover other population groups (optional-eligibility groups). States set individual eligibility criteria within federal minimum standards. There are other nonfinancial eligibility criteria that are used in determining Medicaid eligibility. In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Beginning in October 2013, states were required to use available electronic data sources to confirm information included on the application, while minimizing the amount of paper documentation that consumers need to provide.

As of March 25, 2011, federal regulations require that certain ordering and referring physicians or other professionals providing services under the state plan or under a waiver of the plan must be enrolled as participating providers, which includes screening the providers upon initial enrollment and when follow-up verification occurs (at least every 5 years). The follow-up verification is referred to as revalidation or reenrollment.<sup>11</sup> As part of the enrollment process, and depending on the provider's risk level, states may be required to collect certain information about the providers' ownership interests and criminal background, search exclusion and debarment lists, and take action to exclude those providers who appear on those lists. When state officials discover potentially fraudulent activity in the enrollment process, states must refer that activity or providers to law-enforcement entities for investigation and possible prosecution.

In May 2014 we reported that states have historically provided Medicaid benefits using a fee-for-service system, in which health-care providers are paid for each service.<sup>12</sup> However, according to CMS, in the past 15 years, states have more frequently implemented a managed-care delivery system for Medicaid benefits. In a managed-care delivery system, beneficiaries obtain some portion of their Medicaid services from an

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<sup>11</sup>42 C.F.R. §§ 455.410 and 455.414. CMS does not require provider enrollment for ordering or referring physicians in a risk-based managed-care context. See 76 Fed. Reg. 5862, 5904 (Feb. 2, 2011). These provider enrollment requirements were established during the same year as that of the data we used for our analysis.

<sup>12</sup>GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, [GAO-14-341](#) (Washington, D.C.: May 19, 2014).

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organization under contract with the state, and payments to MCOs are typically made on a predetermined, per person, per month basis. Currently, two-thirds of Medicaid beneficiaries receive some of their services from MCOs, and many states are expanding their use of managed care to additional geographic areas and Medicaid populations.<sup>13</sup> According to HHS, approximately 27 percent, or \$74.7 billion, of nationwide federal Medicaid expenditures in fiscal year 2011 (the fiscal year our review focused on) were attributable to Medicaid managed care. States oversee MCOs that provide care to Medicaid beneficiaries through contracts and reporting requirements, which may include identifying improper payments to providers within their plans.

Several federal and state entities are involved in Medicaid program integrity, including CMS and its Center for Program Integrity, HHS OIG, and state Medicaid agencies and law-enforcement divisions. Federal entities typically provide oversight, as well as program and law-enforcement support. CMS oversight of state program-integrity efforts includes providing guidance related to statutory and regulatory requirements, as well as technical assistance on specific program-integrity activities such as audit and overpayments reporting. The Deficit Reduction Act of 2005 increased the federal government's role by establishing an integrity program to support and oversee state program-integrity efforts.<sup>14</sup> CMS collects information from states on their recoveries of overpayments; however, in November 2012 we reported that most states were not fully reporting recoveries and recommended that CMS increase efforts to hold states accountable for reliably reporting program-integrity recoveries to ensure that states are returning the federal share of recovered overpayments.<sup>15</sup> As of April 2014, CMS had implemented this recommendation. According to CMS, the agency provided training to

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<sup>13</sup>There has been a growing trend in Medicaid program administration in which states are transitioning from a fee-for-service model to a managed-care model.

<sup>14</sup>Pub. L. No. 109-171, § 6034, 120 Stat. 4, 74 (2006) (codified at 42 U.S.C. § 1396u-6). In September 2014, the Center for Program Integrity was reorganized to integrate the Medicare and Medicaid program-integrity functions across the Center for Program Integrity, so that all Center for Program Integrity units are focused on both programs. To achieve Medicare–Medicaid integration, the Medicaid Integrity Group was also reorganized and integrated with Medicare staff so that the Medicaid Integrity Group no longer exists as a separate identifiable unit.

<sup>15</sup>GAO, *Medicaid Program Integrity: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, [GAO-13-50](#) (Washington, D.C.: Nov. 13, 2012).

states through the Medicaid Integrity Institute in April 2014. HHS OIG oversees Medicaid program integrity through its audits, investigations, and program evaluations. It is also responsible for enforcing certain civil and administrative health-care fraud laws. States have primary responsibility for reducing, identifying, and recovering improper payments.

## Indicators of Potentially Improper Medicaid Payments to Beneficiaries and Providers Highlight Potential Weaknesses in Selected State Controls

Of the approximately 9.2 million beneficiaries in the four states that we examined, thousands of cases from the fiscal year 2011 data analyzed showed indications of potentially improper payments, including fraud, to Medicaid beneficiaries and providers. The numbers on beneficiaries and providers may not reflect the total incidence of potentially improper payments, including fraud, because it was not possible to fully investigate claims that did not have a valid SSN. For example, we were unable to match beneficiaries and providers without valid SSNs to the full DMF, making it difficult to fully investigate such cases for other indicators of improper payments or fraud.

### Medicaid Beneficiaries

**Table 1: Potential Improper-Payment Indicators Related to Medicaid Beneficiary Identity for Four Selected States during Fiscal Year 2011**

Potential improper-payment indicator	Approximate number receiving benefits	Estimate of total Medicaid benefits paid (dollars in millions)
Beneficiaries concurrently receiving benefits paid by two or more states	8,600	\$18.3
Deceased beneficiaries	200	9.6
Incarcerated beneficiaries	3,600	4.2

Source: GAO analysis of data provided by the Centers for Medicare & Medicaid Services (CMS); Arizona, Florida, Michigan, and New Jersey state Medicaid programs; the Social Security Administration (SSA); and Arizona, Florida, Michigan, and New Jersey state departments of corrections. | GAO-15-313

Note: Approximately 9.2 million beneficiaries were examined for this report, with Medicaid payments totaling almost \$3.5 billion. The numbers in the columns may not be mutually exclusive, and do not necessarily represent unique beneficiaries. Improper-payment indicators include possible fraud.

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- **Beneficiaries concurrently receiving benefits paid by two or more states.** Under federal regulations, beneficiaries are not to have payments made on their behalf by two or more states concurrently.<sup>16</sup> In some instances, a beneficiary may obtain services in a different state, but his or her resident state should pay for the eligible services. We identified about 8,600 beneficiaries that had payments made on their behalf concurrently by two or more of our selected states. Medicaid approved benefits of at least \$18.3 million for these beneficiaries in these states.
  - **Deceased beneficiaries.** We identified approximately 200 deceased individuals in the four states who appear to have received Medicaid benefits. Specifically, our analysis matching Medicaid data to SSA's full DMF found these individuals were deceased before the Medicaid service was provided. The Medicaid benefits totaled at least \$9.6 million in the year we reviewed for these 200 beneficiaries. These benefits could be an indication of improper or potentially fraudulent payments.
  - **Incarcerated beneficiaries.** About 3,600 individuals received Medicaid benefits while incarcerated in a state prison facility. We have previously reported that identities of incarcerated individuals being used to obtain benefits can be an indicator of fraud or improper payments. In almost 390 cases totaling nearly \$390,000 in payments, the beneficiary supposedly received medical services during the period of incarceration. This suggests possible identity theft since the beneficiary's incarceration would have physically prevented him or her from receiving medical services covered by Medicaid. Medicaid paid about \$3.8 million on behalf of the remaining 3,200 individuals in the form of capitated payments. Federal law prohibits states from obtaining federal Medicaid matching funds for health-care services provided to inmates except when inmates are patients in medical institutions.<sup>17</sup> The intent of the federal prohibition is to ensure that

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<sup>16</sup>Under Medicaid statutes and regulations a state agency must provide Medicaid services to eligible residents of that state. If a resident of one state subsequently establishes residency in another state, the beneficiary's Medicaid eligibility in the previous state should end, subject to appropriate notice and hearing procedures. 42 C.F.R. §§ 431.200-431.246.

<sup>17</sup>42 U.S.C. § 1396d(a). For a service to qualify for federal matching funds, an inmate must be admitted as a patient in a medical facility, such as a hospital, for 24 hours or more, and the admitting facility must meet criteria for being a noncorrectional medical facility.

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federal Medicaid funds do not finance care that is the responsibility of state and local authorities. The claims indicate that the services provided to these 3,600 beneficiaries did not meet the criteria for Medicaid coverage of being inpatient care provided in a medical institution.

Federal law requires states to make Medicaid available to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address. Therefore, there are no requirements related to listing actual physical addresses for beneficiary enrollment and eligibility determinations. However, state officials noted that using a virtual address may be a way to conceal total household income and is a potential indicator of fraud. By using a virtual address, state investigators would not be able to visit the residence and confirm the household composition matches the information on the application. Our analysis involving matching Medicaid data to the USPS address-management tool found that at least 4,400 beneficiaries may have been using a virtual address as their residence address.<sup>18</sup> Specifically, these beneficiaries used a Commercial Mail Receiving Agency (CMRA) address as their residence address.<sup>19</sup> For these beneficiaries, Medicaid paid claims totaling at least \$20.5 million.

Another indicator of potentially fraudulent or improper payments on behalf of Medicaid beneficiaries in the four states we reviewed in fiscal year 2011 pertains to questionable or nonexistent SSNs. Applicants provide these numbers to Medicaid to help confirm their identities. Our analysis of state Medicaid information showed that SSNs for about 199,000 beneficiaries, or about 2.2 percent, of the 8.9 million beneficiaries we examined in the four states did not match identity information contained in SSA databases. The benefits paid on behalf of these 199,000 beneficiaries totaled at least \$448 million for fiscal year 2011. Over

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<sup>18</sup>Our analysis found almost 343,000 beneficiaries with missing addresses or addresses that did not match any USPS records. We also identified 10 beneficiaries with foreign addresses (in Australia, Canada, Israel, the Philippines, and Mexico) as their residence address. Medicaid claims associated with these beneficiaries totaled almost \$30,000. States must provide Medicaid to eligible residents of the state, including residents who are absent from the state. Regulations do not prohibit beneficiaries with foreign addresses as long as they can otherwise meet state residency requirements, but we did not confirm whether beneficiaries met such requirements in these cases.

<sup>19</sup>A CMRA is a third-party agency that receives and handles mail for a client, such as a United Parcel Service store.

12,500 of the beneficiaries used an SSN that was never issued by SSA. These approximately 12,500 beneficiaries accounted for at least \$76 million in Medicaid benefits.

Applications may have inaccuracies due to simple errors such as inaccurate data entry, making it difficult to determine whether these cases involve improper payments or fraud through data matching alone. In addition, there may be situations where an individual does not have an SSN (for example, a newborn child). Nonetheless, these applications raise questions because there is no complete electronic record of beneficiaries' identities, which can be an indicator of identity-related fraud. Identity theft and identity fraud are terms used to refer to all types of crime in which someone wrongfully obtains and uses another person's personal data in some way that involves fraud or deception, typically for economic gain.

## Medicaid Providers

In addition to beneficiaries, we found hundreds of Medicaid providers who were potentially improperly receiving Medicaid payments. As described below, these cases show indications of certain types of fraud or improper benefits.

**Table 2: Potential Improper-Payment Indicators for Medicaid Providers for Four Selected States during Fiscal Year 2011**

Potential improper-payment indicator	Approximate number providing services	Estimate of total Medicaid benefits paid (dollars in millions)
Providers with suspended or revoked licenses in at least one state	90	\$2.8
Providers with Commercial Mail Receiving Agency (CMRA) as virtual addresses	220	0.3
Deceased providers	50	0.2
Excluded providers	50	0.1

Source: GAO analysis of data provided by the Centers for Medicare & Medicaid Services (CMS); the Department of Health and Human Services (HHS) Office of Inspector General (OIG); Arizona, Florida, Michigan, and New Jersey state Medicaid programs; the Social Security Administration (SSA); the General Services Administration (GSA); the Federation of State Medical Boards (FSMB); and the United States Postal Service (USPS). | GAO-15-313

Note: Approximately 881,000 providers were examined for this report with Medicaid payments totaling almost \$3.5 billion. The numbers in the columns may not be mutually exclusive, and do not necessarily represent unique providers. Improper-payments indicators include possible fraud.

- **Providers with suspended or revoked medical licenses.** All physicians applying to participate in state Medicaid programs must

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hold a current, active license in each state in which they practice. During enrollment, states are required to screen out-of-state licenses to confirm the license has not expired and that there are no current limitations on the license. Additionally, states are required to provide CMS with information and access to certain information respecting sanctions taken against health-care practitioners and providers by their own licensing authorities. Using data from the Federation of State Medical Boards (FSMB), we found that approximately 90 medical providers in the four selected states had their medical licenses revoked or suspended in the state in which they received payment from Medicaid during fiscal year 2011. Medicaid approved the associated claims of these cases at a cost of at least \$2.8 million.<sup>20</sup>

- **Invalid addresses for providers.** A drop-box or mailbox scheme is a common fraud scheme in which a fraud perpetrator will set up a medical-oriented business and will use a CMRA as his or her official address. The four states we examined for our review required providers to provide the physical service location of their business when they apply to provide Medicaid services. Our analysis matching Medicaid data to USPS address-management tool data found that at least 220 providers may have inappropriately used a virtual address as their physical service location. Specifically, these providers used a CMRA address as their physical service location. For these providers, Medicaid approved claims of at least \$318,000. Additionally, our analysis found nearly 26,600 providers with addresses that did not match any USPS records. These unknown addresses may have errors due to inaccurate data entry or differences in the ages of MMIS and USPS address-management tool data, making it difficult to determine whether these cases involve fraud through data matching alone.

Our analysis also identified 47 providers with foreign addresses as their location of business. These providers had addresses in Canada, China, India, and Saudi Arabia. Our analysis found that 8 of the 47 providers with foreign addresses had been paid over \$90,000 in Medicaid claims during fiscal year 2011.<sup>21</sup> In December 2010, CMS

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<sup>20</sup>We did not independently verify the final suspension and revocation decisions with the state medical licensing boards.

<sup>21</sup>All 47 providers identified had claims associated with them in the fiscal year 2011 MSIS prescription claims data file, which was not included in this review.

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released guidance on implementing the Patient Protection and Affordable Care Act (PPACA) provisions prohibiting payments to institutions or entities located outside of the United States. CMS's guidance went into effect on June 1, 2011. Approximately 28 percent of the claims we identified occurred after CMS's guidance went into effect.

- **Deceased providers.** We identified over 50 deceased providers in the four states we examined whose identities received Medicaid payments. Our analysis matching Medicaid eligibility and claims data to SSA's full DMF found these individuals were deceased before the Medicaid service was provided. The Medicaid benefits involved with these deceased providers totaled at least \$240,000 for fiscal year 2011. These benefits are an indication of improper or potentially fraudulent payments.
- **Excluded providers.** We found that about 50 providers in the four states we examined had been excluded from federal health-care programs, including Medicaid; these providers were excluded from these programs when they billed for Medicaid services during fiscal year 2011. The selected states paid the claims at a cost of about \$60,000. The federal government can exclude health-care providers from participating in the Medicaid program for several reasons. Excluded providers can be placed on one or both of the following exclusion lists, which state Medicaid officials must check no less frequently than monthly: the List of Excluded Individuals and Entities (LEIE), managed by HHS, and the System for Award Management (SAM), managed by GSA.<sup>22</sup> The LEIE provides information on health-care providers that are excluded from participation in Medicare, Medicaid, and other federal health-care programs because of criminal convictions related to Medicare or state health programs or other major problems related to health care (e.g., patient abuse or neglect). SAM provides information on individuals or entities that are excluded from participating in any other federal procurement or nonprocurement activity. Federal agencies can place individuals or entities on SAM for a variety of reasons, including fraud, theft, bribery, and tax evasion.

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<sup>22</sup>42 C.F.R. § 455.436(c)(2) requires states to check LEIE and the Excluded Parties List System (EPLS). However, GSA discontinued EPLS in 2012 and moved its content to SAM. In August 2012, CMS officials instructed states to use SAM instead of EPLS to fulfill their regulatory responsibilities.

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On the basis of our matching of state prison data to Medicaid claims data, we found that 16 providers in the selected states were incarcerated in state prisons at some point in fiscal year 2011. The offenses that led to incarceration included drug possession, drug trafficking, money laundering, racketeering, and murder. We did not identify any Medicaid claims associated with these providers while they were incarcerated.

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## CMS Has Taken Steps to Strengthen Certain Medicaid Enrollment-Screening Controls, but Gaps Remain

Through regulation, CMS has taken steps since 2011 to make the Medicaid enrollment-verification process more data-driven. The steps may address many of the improper-payment indicators that were found in our 2011 analysis of Medicaid claims; specifically, CMS took regulatory action to enhance beneficiary-screening procedures in 2013 and provider-screening procedures in 2011. However, gaps in guidance and data sharing continue to exist, and additional opportunities for improvements are available for screening beneficiaries and providers.

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## CMS Issued Regulations Requiring States to Access Additional Data Sources to Verify Medicaid Applicant Information

In response to PPACA, which was enacted in 2010, CMS issued federal regulations in 2013 to establish a more-rigorous approach to verify financial and nonfinancial information needed to determine Medicaid beneficiary eligibility. Specifically, under these regulations, states are required to use electronic data maintained by the federal government to the extent that such information may be useful in verifying eligibility. CMS created a tool called the Data Services Hub (hub) that was implemented in fiscal year 2014 to help verify beneficiary applicant information used to determine eligibility for enrollment in qualified health plans and insurance-affordability programs, including Medicaid. The hub routes to and verifies application information in various external data sources, such as SSA and the Department of Homeland Security. According to CMS, the hub can verify key application information, including household income and size, citizenship, state residency, incarceration status, and immigration status.<sup>23</sup> If properly implemented by CMS, the hub can help mitigate some of the potential improper-payment issues that we identified earlier in our

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<sup>23</sup>As discussed earlier and highlighted in table 1, we identified about 3,600 beneficiaries receiving Medicaid benefits while they were incarcerated.

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analysis of fiscal year 2011 Medicaid claims including state residencies, deceased beneficiaries, and incarcerated beneficiaries.<sup>24</sup>

Figure 1 shows beneficiary enrollment procedures that states are required to follow beginning in October 2013. Under CMS's regulations, when states receive an application they are to use the hub to verify an individual's eligibility.<sup>25</sup> CMS regulations state that if the information is not available in the hub, or if there is missing information on the application, the state must use other data sources to determine an individual's eligibility.<sup>26</sup> Further, CMS regulations require state Medicaid offices to use all available electronic data resources before contacting an applicant directly.

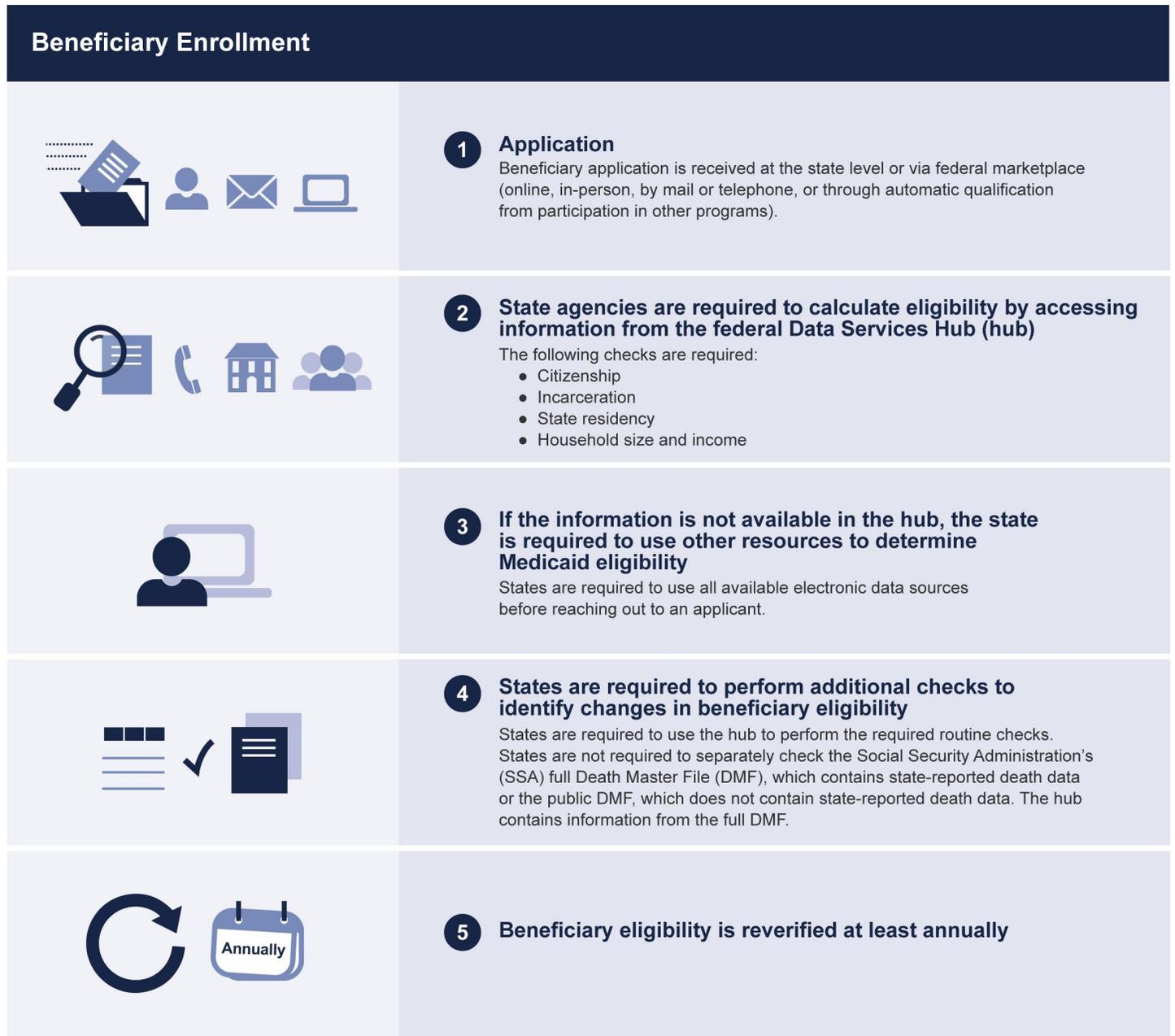
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<sup>24</sup>We have ongoing work that is reviewing the effectiveness of the hub in verification of eligibility. We plan to report on the results of this work later in the calendar year.

<sup>25</sup>Under 42 C.F.R. § 435.945(k), subject to approval by the Secretary, states may request and use information from alternate sources, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and states while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance-affordability programs. The data used for our study are from fiscal year 2011, approximately 3 years prior to implementation of the CMS hub requirement.

<sup>26</sup>42 C.F.R. §§ 435.948–435.956.

**Figure 1: Center for Medicare & Medicaid Services (CMS) Beneficiary-Enrollment Requirements for Medicaid under the Patient Protection and Affordable Care Act (PPACA)**



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Medicaid regulations and policies. | GAO-15-313

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CMS regulations also say that state Medicaid offices generally must perform checks to verify continued beneficiary eligibility at least once every 12 months unless the individual reports a change or the agency has information to prompt a reassessment of eligibility.<sup>27</sup> These reverifications may include residency or death checks. For residency checks, CMS specifically requires that states use the Public Assistance Reporting Information System (PARIS).<sup>28</sup> This system is used, in part, to identify individuals who are enrolled in Medicaid in more than one state. Thus, by using PARIS, states can identify whether beneficiaries are enrolled in another state and appropriately terminate Medicaid benefits so that payments are not concurrently paid for an individual in two or more states.<sup>29</sup> As discussed earlier and highlighted in table 1, we identified about 8,600 beneficiaries receiving Medicaid benefits in two or more states during fiscal year 2011 in the four states we examined. In July 2014, HHS OIG reported that states' participation in PARIS was limited.<sup>30</sup> HHS OIG recommended that CMS issue guidance to help states comply with the requirement for participating in the PARIS match. CMS agreed with the recommendation. As of January 2015, CMS officials stated that the planned date for implementing the recommendation was March 2015.

In accordance with CMS regulations implementing PPACA, states are required to develop, and update as modified, a Medicaid verification plan describing the verification policies and procedures adopted by the state's Medicaid agency. In February 2013, CMS developed and sent to the states a template on which they were to capture whether they performed

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<sup>27</sup>42 C.F.R. § 435.916.

<sup>28</sup>Initiated in 1993, PARIS is a set of computer matches that enables state public-assistance agencies and federal agencies to share information about applicants for and recipients of certain benefits. PARIS allows participating state public-assistance agencies to exchange with other participants the previous quarter's eligibility files for the Temporary Assistance for Needy Families program, Supplemental Nutrition Assistance Program, and Medicaid program. Federal agencies such as the Department of Defense and the Department of Veterans Affairs have likewise signed agreements to participate in PARIS. States can use the PARIS data match to ensure that individuals enrolled in Medicaid or other public-assistance benefits in one state do not receive duplicate benefits in that state Medicaid program or other public-benefit programs in another state.

<sup>29</sup>Florida officials noted that the information in PARIS is dated and use of the system requires a response from another state.

<sup>30</sup>See Department of Health and Human Services, Office of Inspector General, *Public Assistance Reporting Information System: State Participation in the Medicaid Interstate Match Is Limited*, OEI-09-11-00780 (Washington, D.C.: July 2014).

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certain eligibility-verification steps and the extent to which they used electronic databases to verify the eligibility of Medicaid beneficiaries. According to CMS officials, CMS reviews the states' responses to determine whether each state's verification plan is in accordance with the regulations.

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### Gaps Remain for Screening Deceased Beneficiaries in Selected States

Medicaid services to individuals are to cease once a beneficiary dies. Under CMS regulations, states are to screen beneficiaries through the hub, which includes a check using the full DMF to determine whether they are deceased, at the time of initial enrollment as well as on at least an annual basis thereafter. Hence, the extent to which the hub identifies deceased individuals in Medicaid is generally limited to about once every year.

To supplement the death verification check from the hub, states may use other electronic resources they have available, such as state vital records, to identify deceased beneficiaries. While officials at the four states we examined said that they periodically check the state vital records to determine whether a potential Medicaid beneficiary has died, the four states did not use the more-comprehensive full DMF to perform this check outside of the initial enrollment or annual revalidation period.<sup>31</sup> As discussed earlier, and highlighted in table 1, we used the full DMF to identify approximately 200 incidents of potential fraud in these four states in fiscal year 2011. Without using information from the full DMF, states can generally only detect deaths within the state's borders and not prevent or detect benefit payments made for individuals who had their deaths recorded in other states' vital records. Additionally, we previously reported the full DMF contained approximately 40 percent more records than the public DMF for deaths reported in 2012 alone.<sup>32</sup> Moreover, in March 2015, we reported that while verifying eligibility using SSA's death data can be an effective tool to help prevent improper payments to deceased individuals or those that use their identities, agencies may not

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<sup>31</sup>In commenting on a draft of this report, SSA clarified that the agency does not have data-sharing agreements in place with any states for the full DMF, but does provide death indicators derived from the full DMF.

<sup>32</sup>GAO, *Social Security Death Data: Additional Action Needed to Address Data Errors and Federal Agency Access*, [GAO-14-46](#) (Washington, D.C.: Nov. 27, 2013).

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be obtaining accurate data because of weaknesses in how these data are received and managed by SSA.<sup>33</sup>

According to CMS officials, many state Medicaid agencies have long-standing policies of using data matches against both SSA and state vital statistics to identify deceased individuals. SSA has made the full DMF available through the hub for the states' annual redetermination and also has agreements in place to provide death indicators based on the full DMF to states. In commenting on the draft of this report, SSA officials stated that the agency also provides the full DMF to CMS. Thus, states should be able to access this death information directly from CMS, according to SSA. While the federal regulation requires states to check the hub for such items as citizenship and incarceration, CMS officials noted that the federal regulation does not specify how deceased individuals should be identified nor has CMS explored the feasibility of states using the full DMF in the periodic screening for deceased individuals, outside of the initial enrollment or the annual revalidation period. As a result, states may not be able to detect individuals who have moved to and died in other states and prevent payment of potentially fraudulent benefits.

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## CMS Issued Guidance for Screening Provider Enrollment

PPACA authorized CMS to implement several actions to strengthen provider-enrollment screening. CMS and HHS OIG issued a final rule in February 2011, effective March 2011, to implement many of the new screening procedures. This final rule, if properly implemented, will address some of the issues that we found in our analysis of fiscal year 2011 data, such as screening of excluded providers.

As shown in figure 2, to enroll in Medicaid directly with the state, providers must apply to the state Medicaid office. While PPACA requires that all providers and suppliers be subject to licensure checks, it gave CMS discretion to establish a risk-based application of other screening procedures.<sup>34</sup> As part of the February 2011 regulation, CMS determined

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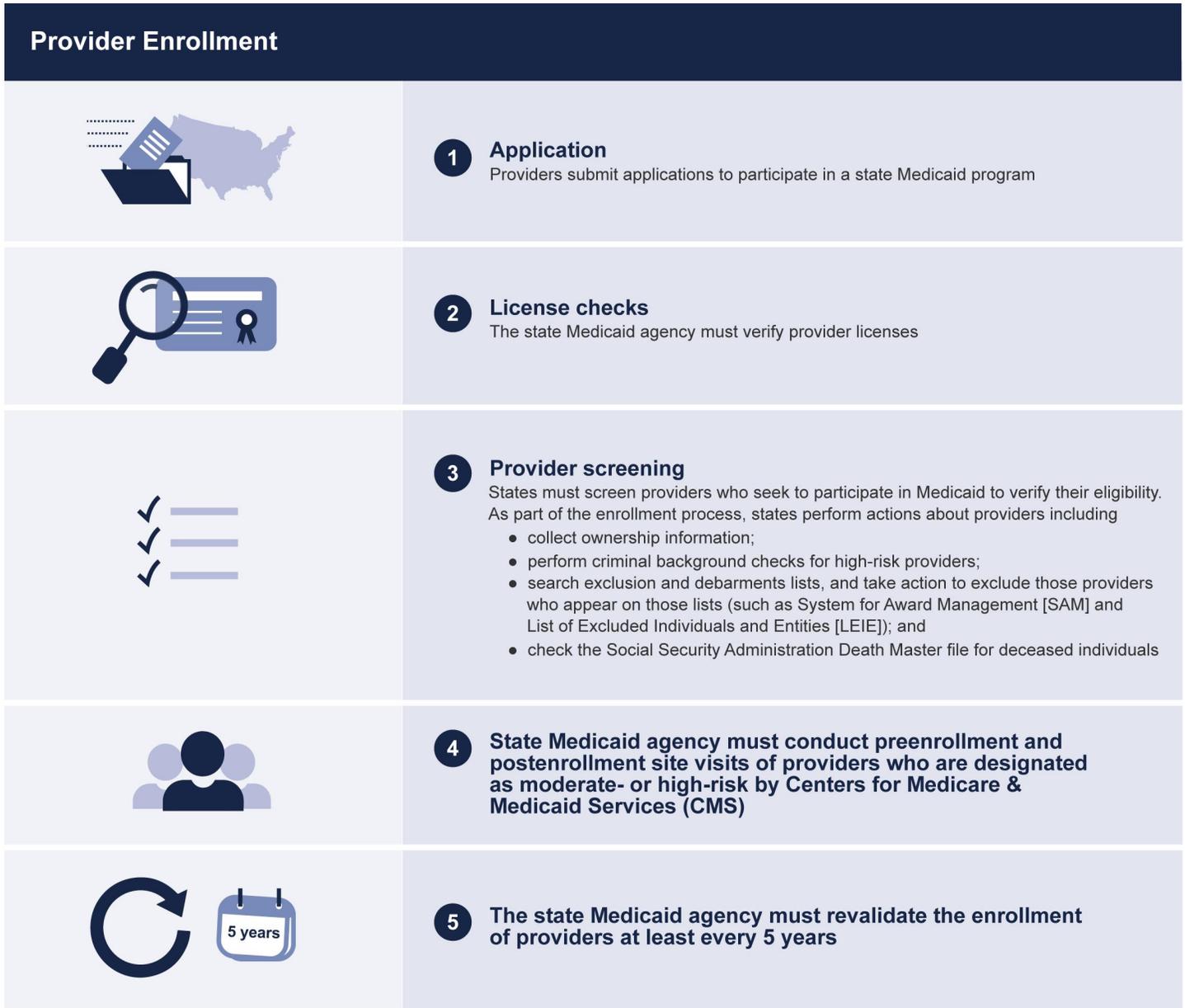
<sup>33</sup>GAO, *Improper Payments: Government-Wide Estimates and Use of Death Data to Help Prevent Payments to Deceased Individuals*, [GAO-15-482T](#) (Washington, D.C.: Mar. 16, 2015).

<sup>34</sup>CMS and state Medicaid programs are not required to use the FSMB database that we used in our study.

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that states must continue to verify providers and suppliers using various data sources, such as the full DMF, National Plan and Provider Enumeration System, LEIE, and SAM. According to CMS's risk-based screening, moderate- and high-risk providers and suppliers additionally must undergo unscheduled or unannounced site visits, while high-risk providers and suppliers also will be subject to fingerprint-based criminal-background checks. This requirement may address some of the potentially fraudulent or improper payments highlighted in table 2, including approximately 200 providers with a CMRA or foreign address. Additionally, the regulations require the state Medicaid agency to revalidate providers at least every 5 years. Because the regulation was effective in March 2011, the states are required to complete revalidation for Medicaid providers in their states by March 2016.

**Figure 2: Centers for Medicare & Medicaid Services Provider Enrollment Requirements for Medicaid under the Patient Protection and Affordable Care Act (PPACA)**



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Medicaid regulations and policies. | GAO-15-313

Note: According to the Department of Health and Human Services (HHS) 2011 regulation, only those physicians and other professionals receiving payments for services directly from state Medicaid agencies are required to enroll in the state Medicaid program.

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We found that the states in our review had different methods for identifying deceased providers.<sup>35</sup> Specifically, according to officials in one state we examined, Arizona, the state uses the public DMF to periodically screen providers.<sup>36</sup> Michigan uses a private-company dataset in monitoring providers for, among other things, deaths; however, the dataset used is not the full DMF but the public DMF, which excludes state-reported death data. New Jersey officials stated that they use a different source of death data—an Internet genealogy website—to check for deceased providers during the application process. According to the genealogy website, it includes deaths from SSA through 2011 and contains updated obituaries from newspapers.

In addition, according to HHS, providers must hold a valid professional license before enrolling in Medicaid. CMS regulations require states to verify licenses in states in which the provider is enrolling and in each of the other states in which the provider purports to be licensed, as well. Two states we examined, Arizona and Michigan, review licenses throughout the country. Arizona uses the National Practitioner Data Bank for license verification. The National Practitioner Data Bank is an HHS nationwide system that is primarily an alert or flagging system intended to facilitate a comprehensive review of the professional credentials of health-care practitioners, health-care entities, providers, and suppliers. The National Practitioner Data Bank contains adverse actions including certain licensure, clinical privileges, and professional-society membership actions, as well as Drug Enforcement Administration controlled-substance registration actions, and exclusions from participation in Medicare, Medicaid, and other federal health-care programs. Michigan, on the other hand, uses a private-company dataset that periodically monitors providers for licenses and licensure actions. New Jersey and Florida both screen the providers within their states, as required. However, neither state uses a nationwide system, such as FSMB or the National Practitioner Data Bank, to validate licenses or determine whether the provider has been

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<sup>35</sup>As discussed earlier and highlighted in table 2, we identified about 50 providers that received Medicaid payments during fiscal year 2011 for services rendered after they were deceased.

<sup>36</sup>In its comments on a draft of this report, SSA stated that it does not provide the full DMF to any state Medicaid program.

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sanctioned.<sup>37</sup> Although each state generally had a different process for verification, which is allowable under Medicaid, all four states periodically reviewed licenses to ensure that providers are licensed to practice medicine in their states to meet the CMS requirement.

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## Federal Regulation on Enrollment Does Not Apply to MCO Providers

According to CMS's February 2011 regulation, ordering and referring providers participating in Medicaid in a risk-based managed-care environment are not required to enroll in Medicaid, and therefore are not subject to screening provisions discussed previously. As explained in its final rule, HHS did not require Medicaid managed-care providers to enroll with Medicaid programs because doing so would have resulted in unequal treatment of managed-care providers under the Medicare program, which does not require managed-care providers to enroll. Although not required, HHS officials stated that they do encourage states to screen managed-care network providers.

In this regard, in May 2014, we reported that neither state nor federal entities are well positioned to identify improper payments made to MCOs, nor are they able to ensure that MCOs are taking appropriate actions to identify, prevent, or discourage improper payments.<sup>38</sup> We stated that improving federal and state efforts to strengthen Medicaid managed-care program integrity takes on greater urgency as states that choose to expand their Medicaid programs under PPACA are likely to do so with managed-care arrangements, and will receive a 100 percent federal match for newly eligible individuals from 2014 through 2016. As we reported in May 2014, unless CMS takes a larger role in holding states accountable, and provides guidance and support to states to ensure adequate program-integrity efforts in Medicaid managed care, the gap between state and federal efforts to monitor managed-care program integrity will leave a growing portion of federal Medicaid dollars vulnerable to improper payments. In the May 2014 report, we recommended that CMS increase its oversight of program-integrity efforts by requiring, in part, that CMS update its guidance on Medicaid managed-care program

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<sup>37</sup>New Jersey does verify licenses from its neighboring states of Delaware, New York, and Pennsylvania. Additionally, the New Jersey Office of the State Comptroller–Medicaid Fraud Division stated that it utilizes a national website to validate licenses and determine whether a provider has been sanctioned, but only for high- and moderate-risk provider-type applications submitted to the state for enrollment into the Medicaid program.

<sup>38</sup>[GAO-14-341](#).

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integrity. In May 2014, HHS agreed with our recommendation, but as of February 2015 had not issued new guidance.

Officials in Arizona, Florida, and Michigan said that their respective states require that all managed-care network providers enroll or register with the state Medicaid agency. We believe this standardization potentially eliminates discrepancies found in states when the credentialing standards for the managed-care network may differ from the state's enrollment processes, and the state relies on contracted MCOs to collect network-provider disclosures, check providers and affiliated parties for exclusions, and oversee other aspects of the provider-enrollment process. Thus, by requiring that all MCO providers be enrolled directly with the states, those three states maintain centralized control over the screening and registration process and may be better positioned to ensure the integrity of their Medicaid programs.

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### Challenges in Data Sharing Hamper Selected States from More-Efficiently Screening for Provider Enrollment Fraud

We have found that fraud prevention is the most efficient and effective means to minimize fraud, waste, and abuse rather than trying to recover payments once they are made.<sup>39</sup> Thus, controls that prevent potentially fraudulent health-care providers from entering the Medicaid program or submitting claims are the most-important element in an effective fraud-prevention program. Effective fraud-prevention controls require that, where appropriate, organizations enter into data-sharing arrangements with each other to perform validation. System edit checks (i.e., built-in electronic controls) are also crucial in identifying and rejecting potentially fraudulent enrollment applications.<sup>40</sup>

Although CMS has taken steps through its program regulations in providing guidance to states for screening providers, the states we examined reported difficulties in implementing the regulations. One provision in the 2011 HHS regulation allowed states to rely on the results of provider screening by Medicare contractors to determine provider eligibility for Medicaid. According to HHS, this provision would eliminate

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<sup>39</sup>[GAO-06-954T](#).

<sup>40</sup>System edit checks are prepayment or postpayment computerized tests to detect inaccuracies in eligibility, reporting, and payment. For additional discussion of these issues, including associated challenges, please see our overview of the GAO data analytics forum: GAO, *Highlights of a Forum: Data Analytics for Oversight and Law Enforcement*, [GAO-13-680SP](#) (Washington, D.C.: July 15, 2013).

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additional screening and enrollment requirements for Medicaid providers, and also eliminate additional costs and burdens for separate screening for state Medicaid programs.

To administer the provider screening, application fee, and revalidation requirements successfully, as specified in federal regulations,<sup>41</sup> CMS determined that states must have access to Medicare enrollment data to determine whether a provider is currently enrolled in the Medicare program, has been denied enrollment, or is currently enrolling. According to CMS, in April 2012, CMS established a process by which states would have direct access to Medicare’s enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS). Each state is given “read only,” manual access to PECOS. CMS provided the states access to PECOS in hopes that the states will be able to use these data in minimizing the amount of screening and costs that are associated with providers that are already enrolled in Medicare.

However, according to our discussions with officials in the four selected states, the states are using PECOS to screen a segment of their provider population but none currently utilize PECOS for their entire provider population. Arizona officials stated that they use PECOS in the screening of out-of-state providers. Michigan officials stated that they use PECOS on medium- or high-risk providers to determine whether a site visit is warranted. New Jersey officials stated they use PECOS to confirm an out-of-state provider’s Medicare provider status and view the results of the most-recent site-visit inspection. Florida officials said that they do not screen all providers using PECOS. With regard to using PECOS for all Medicaid providers in their screening processes, we determined the following:

- State officials told us that PECOS required manual lookups of individual providers, a task that one state characterized as inefficient and administratively burdensome.<sup>42</sup> According to CMS officials, as of October 2013, CMS began providing all interested states access to a monthly PECOS data-extract file that contains basic Medicare enrollment information; the state officials we interviewed were unaware that they could obtain automated data extracts from PECOS.

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<sup>41</sup>42 C.F.R. §§ 455.410, 455.414, 455.450, and 455.460.

<sup>42</sup>Officials stated that large-scale batch matching is not possible, so they must check each provider in PECOS individually.

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- Additionally, state officials from Florida, Michigan, and New Jersey said that they use a limited amount of pertinent information, specifically site-visit information, from PECOS to perform the necessary provider screening. However, there is additional information in PECOS, such as ownership information, that is necessary for state Medicaid agencies to screen providers properly and that is not included in the information that they use. Only Arizona officials stated they are able to utilize PECOS ownership information for providers. According to CMS officials, ownership information on providers can be obtained through a detailed-level view of PECOS. However, CMS has not made ownership information available to the states through the monthly PECOS data-extract file.

Some state officials noted that full electronic access to all information in the PECOS system would streamline provider-screening efforts, resulting in a more-efficient and more-effective process. Additional CMS guidance to the states on requesting automated information through PECOS and ensuring that such information includes key ownership information could help states improve efficiency of provider screening.

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## Conclusions

The Medicaid program is a significant expenditure for the federal government and the states, representing over \$310 billion in federal outlays in fiscal year 2014. Because of the size and continued expansion of the Medicaid program, it is important that the federal government and the states continue to find ways to prevent and reduce improper payments, including fraud, in the program. Since 2011, CMS has taken steps to strengthen Medicaid beneficiary and provider enrollment-screening controls. As part of this ongoing endeavor, increasing information and data-sharing efforts between the federal government and state Medicaid programs could help enhance efforts to identify improper payments and potentially fraudulent activities. As the federal overseer of the Medicaid program, CMS is well positioned to provide additional guidance on accessing information in federal databases, such as SSA information about deceased individuals and automated information on providers through Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS)—that would help identify and prevent benefits and payments to those individuals and providers who are ineligible to participate in Medicaid.

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## Recommendations for Executive Action

To further improve efforts to limit improper payments, including fraud, in the Medicaid program, we recommend that the Acting Administrator of CMS take the following two actions:

- issue guidance to states to better identify beneficiaries who are deceased; and
- provide guidance to states on the availability of automated information through Medicare’s enrollment database—the Provider Enrollment, Chain and Ownership System (PECOS)—and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

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## Agency and Third-Party Comments and Our Evaluation

We provided a draft copy of this report to HHS, SSA, and state Medicaid program offices for Arizona, Florida, Michigan, and New Jersey. Written comments from HHS, SSA, the Arizona Health Care Cost Containment System (AHCCCS), the Florida Agency for Healthcare Administration, and the Michigan Department of Community Health are summarized below and reprinted in appendixes II–VI. HHS concurred with our recommendations. SSA did not comment on the findings and recommendations but provided clarifying comments on the full DMF. AHCCCS disagreed with our methodology and provided detailed comments on our findings, as described below. The Florida Agency for Healthcare Administration said it supports our efforts to identify provider and beneficiary fraud. The Michigan Department of Community Health agreed with our findings and supports our recommendations. In an e-mail received on March 24, 2015, the Chief of Investigations of the New Jersey Office of the State Comptroller, Medicaid Fraud Division, did not provide comments on the findings but provided a technical comment, which we incorporated as appropriate. The Florida Department of Children and Families also provided technical comments, which we incorporated as appropriate.

HHS concurred with both of our recommendations. Regarding our first recommendation, to issue guidance to states to better identify beneficiaries who are deceased, HHS stated that it will work with states to determine additional approaches to better identify deceased beneficiaries and continue to provide state-specific technical assistance as needed. In response to our second recommendation, HHS indicated that it will continue to educate states about the availability of PECOS information and how to use that information to help screen Medicaid providers more effectively and efficiently. HHS also outlined steps the agency has taken to address beneficiary and provider eligibility fraud since fiscal year

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2011—the time frame for the data used in our study—many of which were mentioned in our report. As described in our report, we used fiscal year 2011 data because it was the most-recent consistently comparable data available.

In its written comments, SSA did not comment on the report's findings and recommendations but provided clarifying information regarding access to the full Death Master File (DMF), which we incorporated as appropriate. Additionally, SSA stated that CMS already has access to the full DMF and can share that information with states to ensure proper payment of Medicaid benefits. We believe that such action by CMS could address our first recommendation.

In its written comments, AHCCCS said that it takes exception to being included in a series of findings that are global in nature and offer no state-specific detail. As we noted in our meetings with all state agencies included in our study, we did not provide state-level detail for two primary reasons. First, because CMS was the audited agency for our work, conducting analysis at the state-level would be outside the scope of our work and would put the focus on a comparison between the states, rather than on CMS oversight. In addition, due to the age and limitations of the data, as noted in the report, we would not be referring specific cases for follow-up. AHCCCS further stated that our report contained misstatements that cannot be attributed to either state. Because AHCCCS did not provide any examples, we cannot address this assertion but stand by the findings and recommendations in our report.

AHCCCS also stated that most of the findings on our report are derived from data sources that are considered unreliable. In our report, we outline the steps we took to assess the reliability of our data and determine that they were sufficiently reliable for performing our work. Additionally, we note the key limitations of the data sources we use for our report and provide the appropriate caveats, as applicable, for the findings from our data analysis. Further, AHCCCS uses several of the same data sources for its eligibility screening as we used in our report. For example, AHCCCS notes that Arizona has found that the SSA death file is unreliable. It further notes that it uses SSA's real-time State Online Query system to obtain date of death information. According to SSA in its written response to the draft report, the source for the State Online Query system data used by Arizona is the SSA DMF.

AHCCCS also states that the findings of our report do not reflect the current eligibility-screening process in Arizona. We acknowledge the

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limitations stemming from the age of the MSIS data (fiscal year 2011) and the passage of PPACA in 2011. Furthermore, we directly address this limitation in the report where we discuss actions CMS has taken to strengthen certain Medicaid enrollment-screening controls. Specifically, we state that CMS has taken regulatory action since 2011 to enhance beneficiary-screening procedures and provider-screening procedures that may address the improper-payment indicators found in our report. We then discuss the current eligibility-screening process at the federal and state level. We did not make any changes to the report based on these AHCCCS comments, because we believe the essence of the comments was already acknowledged within the report.

AHCCCS also provided comments on specific sections of our analysis, beginning with incarcerated beneficiaries. First, AHCCCS identified reliability and timeliness issues with the SSA incarceration file. This comment is not pertinent to our work, as this file was not a data source used in our analysis. As we note in appendix I, we used each state's department of corrections prisoner database for individuals incarcerated for any period during fiscal year 2011. Second, AHCCCS states that we failed to distinguish whether incarcerated individuals were hospitalized. To the contrary, we note that we reviewed these claims' type of service to determine that none qualified for federal matching funds. Accordingly, this would exclude individuals that were hospitalized.

Regarding our analysis using the USPS address-management tool, AHCCCS incorrectly states that our report assumes that all physical addresses are known to USPS. We do not state this in our report. Specifically, the report notes that federal law requires states to make Medicaid available to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address. Therefore, there are no requirements related to listing actual physical addresses for beneficiary enrollment and eligibility determinations. Further, the focus of our analysis was CMRAs used as the residential address, not the validity of all addresses listed on beneficiary applications. As such, the comment from AHCCCS is not supported by the actual content and analyses in our report.

AHCCCS notes that our analysis of provider controls is an extrapolation from the combined set of states' data. This is incorrect. Our report does not extrapolate, or make any population estimates, of provider eligibility fraud. We provided a descriptive analysis of potential improper payments and provider-eligibility fraud based on the data from fiscal year 2011. As stated earlier, we listed the appropriate caveats to our findings to ensure

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that the results of our analysis were not taken in an inappropriate context, as implied by AHCCCS.

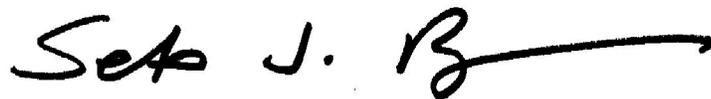
Finally, AHCCCS identified three recommendations that it believes would improve Medicaid program-integrity issues. Specifically AHCCCS stated CMS should

- allow states to use disclosures conducted by Medicare or another state Medicaid program in the enrollment of Medicaid providers,
- allow states to access the federal criminal database to conduct initial and periodic background checks on providers, and
- promote other national initiatives for data sharing on Medicare and provider license verifications.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Commissioner of Social Security, relevant state agencies, and interested congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-6722 or [bagdoyans@gao.gov](mailto:bagdoyans@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VII.

A handwritten signature in black ink that reads "Seto J. Bagdoyan" with a long horizontal line extending to the right.

Seto J. Bagdoyan  
Director, Audit Services  
Forensic Audits and Investigative Service

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# Appendix I: Objectives, Scope, and Methodology

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In this report, we (1) identify and analyze indicators of improper or potentially fraudulent payments to Medicaid beneficiaries and providers and (2) examine the extent to which federal and state oversight policies, controls, and processes are in place to prevent and detect fraud and abuse in determining eligibility for Medicaid beneficiaries and enrolling providers.

To identify indicators of improper or potentially fraudulent payments to Medicaid beneficiaries and providers, we obtained and analyzed Medicaid claims paid in fiscal year 2011, the most-recent consistently comparable data, for four states: Arizona, Florida, Michigan, and New Jersey. Medicaid payments to these states constituted about 13 percent of all Medicaid payments made during fiscal year 2011. These four states were selected primarily because they had reliable data and were among states with the highest Medicaid enrollment.<sup>1</sup> The results of our analysis of these states cannot be generalized to other states. We obtained Centers for Medicare & Medicaid Services (CMS) Medicaid Statistical Information System (MSIS) beneficiary, provider, and other services claims data, as well as state Medicaid Management Information System (MMIS) claims identification data to perform our work. Managed-care organizations (MCO) receive a monthly capitated payment.<sup>2</sup> As a result, the Medicaid paid amounts associated with managed care may not be reflected in the state claims that were submitted to CMS for medical services, and hence our estimate is likely understated. All of the states included in our review—Arizona, Florida, Michigan, and New Jersey—had MCO arrangements in place.

To identify beneficiaries that submitted applications with identification information (name, date of birth, and Social Security number [SSN]) that

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<sup>1</sup>We vetted 11 states for possible inclusion in our study—Arizona, California, Florida, Illinois, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas. We selected states based on high Medicaid beneficiary enrollment, geographic diversity, and availability of data. In the selection process, we also considered whether services were paid under fee-for-service or managed-care organizations (MCO), by including states that used these programs in our review. On the basis of our discussions with agency officials and our own testing, we concluded that the data elements from the four selected states used in this report were sufficiently reliable for our purposes.

<sup>2</sup>Under managed-care arrangements, states contract with MCOs to deliver care through networks. States typically pay the MCOs a fixed amount each month, called a capitation payment. Approximately 70 percent of Medicaid enrollees are served through managed-care delivery systems, where providers are paid at a monthly capitation payment rate.

did not match with Social Security Administration (SSA) records, we used the SSA Enumeration Verification System. Specifically, we processed unique beneficiary identification information from the MSIS and MMIS files through the SSA Enumeration Verification System to determine the extent to which SSN information in the MSIS files was accurate. We analyzed the output codes from the SSA Enumeration Verification System to identify unique individuals who had Medicaid application identification information that did not match SSA records. Applications may have inaccuracies due to simple errors such as inaccurate data entry or incomplete sections, making it difficult to determine whether these cases involve fraud through data matching alone. In addition, there may be situations where an individual does not have an SSN (for example, a newborn child). Nonetheless, these applications pose a higher risk of fraud because there is no complete electronic record of beneficiaries' identities.

To identify providers and beneficiaries with identities associated with deceased individuals at the time of their Medicaid services, we matched Medicaid data—MMIS and MSIS—to the SSA complete file of death information from October 2012. We matched records using the SSN and full name of the individual. We then identified unique individuals who had Medicaid claims processed where the date of death in the SSA file occurred before the beginning service date in the Medicaid claims file.

To identify providers and beneficiaries with identities associated with incarcerated individuals at the time of their Medicaid services, we matched our selected states' MMIS data to the states' departments of corrections prisoner databases. Prisoner data included individuals incarcerated for any period during fiscal year 2011. For Arizona, Florida, and New Jersey, we identified provider and beneficiary records for which the Medicaid SSN and names matched that of a person who was incarcerated in fiscal year 2011 in any of the four states. Michigan did not provide SSNs in its incarceration data. For Michigan, we identified provider and beneficiary records for which the Medicaid name and birth day exactly matched that of a person who was incarcerated in fiscal year 2011 in any of the four states. We then identified Medicaid claims associated with the identified individuals by matching to the MSIS data. We compared the beginning service date of the claims to the individual's admittance and release date to identify all claims that occurred while the associated beneficiary or provider identity was incarcerated. Additionally, we reviewed these claims' type of service to determine that none qualified for federal matching funds.

It is not possible to determine from data matching alone whether these matches definitively identify recipients who were deceased or incarcerated without reviewing the facts and circumstances of each case. For example, it is possible that individuals can be erroneously listed in the full Death Master File (DMF). Similarly, a provider or beneficiary may have an SSN, name, and date of birth similar to an individual in state prison records. Alternatively, our matches may also understate the number of deceased or incarcerated individuals receiving assistance because matching would not detect applicants whose identifying information in the Medicaid data differed slightly from their identifying information in other databases.

To identify claims that are associated with missing or invalid addresses, we used the United States Postal Service (USPS) Address Matching System Application Programming Interface (USPS address-management tool). To identify providers and beneficiaries with invalid addresses, we submitted all MMIS data through that USPS address-management tool for fiscal year 2014. The USPS address-management tool provides information such as whether an address is undeliverable, unknown, a Commercial Mail Receiving Agency (CMRA), or contains an invalid city, state, or ZIP code. Additionally, the address-management tool standardized and corrected addresses based on the information submitted. We considered invalid addresses to be unknown/blank, CMRAs, or foreign addresses. To identify providers with CMRAs, we identified all records where the address-management tool identified and confirmed the address with private-mailbox-number information. We conducted further analysis to remove any provider records that were not for the physical service location of their business, such as a billing or correspondence address for a provider. To identify beneficiaries with commercial addresses, we identified all records where the address-management tool identified the residential address as a commercial address with or without private-mailbox-number information. To identify providers and beneficiaries with unknown addresses, we identified all records where the USPS address-management tool identified the address as not found or blank. To identify providers and beneficiaries with foreign addresses, we identified and reviewed all records where the USPS address-management tool identified the address as having an invalid city or state. We removed records that had been corrected by the USPS address-management tool as well as military bases. We then conducted additional analysis to identify MSIS claims associated with both the providers and beneficiaries with invalid addresses. It is not possible to determine through data matching alone whether the identified claims were definitely associated with invalid addresses without reviewing

additional information for each claim due to the difference in MMIS and address-management tool data age. For example, it is possible that an address was valid in fiscal year 2011 and was no longer recognized in fiscal year 2014.

To identify Medicaid beneficiaries who received benefits in two or more states concurrently, we identified all beneficiary SSNs that appeared in two or more states' MMIS data in fiscal year 2011. We then found all claims associated with the beneficiary identities. We conducted further analysis to determine the states in which each beneficiary identity appears and the service ranges—first and last date of service—for those states. We defined a concurrent claim as a claim that occurred within the service range of a second state for the same beneficiary identity. For each claim, we compared its date of service to the service ranges for the beneficiary identity to determine whether it was a concurrent claim. It is not possible to definitely say through data matching alone that a beneficiary was improperly receiving Medicaid benefits in two or more states concurrently without looking into further information for each claim and beneficiary. For example, a beneficiary could have been a resident in one state and received services, then changed residency to a second state and received benefits for a brief period, before finally relocating again back to the original state and receiving additional services. In this case, the claims could have been identified as a concurrent claim even if the beneficiary did not receive any services from the original state during his or her relocation period in the second state.

To identify claims that might have been improperly processed and paid by the Medicaid program because the federal government had excluded these providers from providing services to Medicaid beneficiaries, we compared the Medicaid claims to the exclusion and debarment files from the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) and the General Services Administration (GSA). Specifically, we used the HHS List of Excluded Individuals and Entities (LEIE) file from September 2012 and the GSA Excluded Parties List System (EPLS) database extract from October 2011 to perform our match. We matched MMIS and MSIS Medicaid data using SSN and individual name with both the LEIE and the EPLS data extracts. We then identified unique individuals who had Medicaid claims processed where the date of exclusion occurred before the beginning service date in the Medicaid claims file.

To identify claims that might be improperly processed and paid by the Medicaid program because the provider had a revoked or suspended

license, we compared Medicaid claims data to the Federation of State Medical Boards (FSMB) Physician Data Center database extract from calendar year 2014. We identified providers with actions that, in some cases, may be prohibited under federal Medicaid regulations that resulted in a suspended or revoked license. We matched these providers with our Medicaid claims data by SSN and provider name. We identified unique individuals who had Medicaid claims processed where the date of license action occurred before the beginning service date in the Medicaid claims file.

To identify federal and state oversight policies, controls, and processes in place to prevent and detect fraud and abuse in determining eligibility for Medicaid beneficiaries and enrolling providers, we reviewed federal statutes, CMS regulations, and state Medicaid policies pertinent to program-integrity structures, met with agency officials, and visited state Medicaid offices that perform oversight functions. We used federal standards for internal control,<sup>3</sup> GAO's Fraud Prevention Framework,<sup>4</sup> federal statutes, and Medicaid eligibility regulations to evaluate these functions.

To determine the reliability of the data used in our analysis, we performed electronic testing to determine the validity of specific data elements in the federal and selected states' databases that we used to perform our work. We also interviewed officials responsible for their respective databases, and reviewed documentation related to the databases and literature related to the quality of the data. On the basis of our discussions with agency officials and our own testing, we concluded that the data elements used for this report were sufficiently reliable for our purposes.

We identified criteria for Medicaid fraud controls by examining federal and state policies, laws, and guidance, including policy memos and manuals. We interviewed officials from CMS and the state governments of Arizona, Florida, Michigan, and New Jersey involved in Medicaid program administration and Medicaid fraud response.

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<sup>3</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21](#).3.1 (Washington, D.C.: November 1999).

<sup>4</sup>GAO, *Individual Disaster Assistance Programs: Framework for Fraud Prevention, Detection, and Prosecution*, [GAO-06-954T](#) (Washington, D.C.: July 12, 2006).

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We conducted this performance audit from March 2014 to May 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our audit findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

APR 16 2015

Seto Bagdoyan  
Director, Forensic Audits  
and Investigative Service  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*" (GAO-15-313).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL ACTIONS NEEDED TO HELP IMPROVE PROVIDER AND BENEFICIARY FRAUD CONTROLS (GAO-15-313)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from Government Accountability Office (GAO) to review and comment on this draft report.

HHS is strongly committed to program integrity efforts in Medicaid. While the GAO analyzed data from 2011, HHS has taken a number of steps to address provider and beneficiary eligibility fraud since that time.

As part of strengthening the Medicaid provider enrollment process, in February 2011, HHS issued regulations to implement categorical risk-based screening of newly enrolling Medicaid providers and revalidate all current Medicaid providers under new requirements established by the *Affordable Care Act*. Categories of risk include factors such as the type of service provided and history of previous adverse actions. Limited risk providers undergo verification of licensure, verification of compliance with federal regulations and state requirements, and perform various database checks. Moderate and high risk providers undergo additional screening, including unannounced site visits. Additionally, as a condition of enrollment, states must require high risk providers or persons with 5 percent ownership interest in a high risk provider to consent to criminal background checks including fingerprinting.

HHS has been proactive about assisting states with provider enrollment and revalidation screening. In April 2012, we provided states with direct access to Medicare's enrollment database—the Provider Enrollment, Chain, and Ownership System (PECOS). In October 2013, in response to input from states, HHS began providing access to monthly PECOS data extracts that states could use to systematically compare state enrollment records against available PECOS information. We have also provided states with training and technical assistance on using PECOS.

HHS has also worked to help states share and access information about terminated providers. In 2011, we provided states with tools to view information on Medicare providers and suppliers in a denied or revoked status and to share information about terminated Medicaid providers terminated from Medicaid programs in other states. In 2014, this process was further improved through the implementation of a new Medicaid termination system. State Medicaid programs can access this repository of all state-submitted Medicaid provider terminations and Medicare provider revocations.

In 2012, HHS issued regulations to require states to use the Data Services Hub (Hub) to verify applicant eligibility upon enrollment and at least annually thereafter. States are able to use this to identify applicants and beneficiaries who may be incarcerated, deceased, or do not meet Medicaid eligibility requirements. States can also validate applicants' Social Security Numbers (SSNs) using the Hub. In 2012, HHS required every state to submit a verification plan describing their verification policies and procedures including the fact that the state verifies SSNs.

States are also required to use the Public Assistance Reporting Information System (PARIS) to identify individuals who are enrolled in Medicaid in more than one state. We plan to provide additional guidance to help states participate in the PARIS match over the coming months.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL ACTIONS NEEDED TO HELP IMPROVE PROVIDER AND BENEFICIARY FRAUD CONTROLS (GAO-15-313)**

GAO's recommendations and HHS' responses are below.

**GAO Recommendation**

Issue guidance to states to better identify beneficiaries who are deceased

**HHS Response**

HHS concurs with GAO's recommendation. Through the Hub, states are able to conduct a data match with the master death file maintained by SSA to identify beneficiaries who are deceased. HHS will work with states to determine additional approaches to better identify deceased beneficiaries. We will also continue to provide state-specific technical assistance as needed.

**GAO Recommendation**

Provide guidance to states on the availability of automated information through Medicare's enrollment database—the Provider Enrollment, Chain, and Ownership System (PECOS)—and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

**HHS Response**

HHS concurs with GAO's recommendation. In October 2013, HHS began providing states access to monthly PECOS data extracts that could be used to systematically compare state enrollment records against available PECOS information. HHS has provided states with training and technical assistance on using the provided tools through Medicaid Integrity Institute sessions and webinars. HHS will continue to educate states about the availability of PECOS information and how to use that information to help screen Medicaid providers more efficiently and effectively.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

# Appendix III: Comments from the Social Security Administration

Note: Page numbers in the draft report may differ from those in this report.



**SOCIAL SECURITY**  
Office of the Commissioner

April 07, 2015

Mr. Seto Bagdoyan  
Director, Forensic Audits and Investigative Service  
United States Government Accountability Office  
441 G. Street, NW  
Washington, DC 20548

Dear Mr. Bagdoyan,

Thank you for the opportunity to review the draft report, "MEDICAID: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls" (GAO-15-313). Please find attached our comments.

If you have any questions, please contact me at (410) 965-0520. Your staff may contact Gary S. Hatcher, Senior Advisor for Records Management and Audit Liaison Staff, at (410) 965-0680.

Sincerely,

A handwritten signature in black ink, appearing to read "Frank Cristaudo".

Frank Cristaudo  
Executive Counselor to the Commissioner

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE, MD 21235-0001

**COMMENTS ON THE GOVERNMENT ACCOUNTABILITY OFFICE DRAFT REPORT, "MEDICAID: ADDITIONAL ACTIONS NEEDED TO HELP IMPROVE PROVIDER AND BENEFICIARY FRAUD CONTROLS" (GAO-15-313)**

This audit touches on our provision of death information to other Government agencies. It is essential that the report accurately summarize the States' access to all of the death information we maintain. We would like to clarify this information, and ask that GAO consider and incorporate our comments into the final version of the report.

We believe there is a general misunderstanding concerning the "full Death Master File (DMF)" and the public DMF, as well as what information we provide to the States. We noted the discrepancies in the following sections below:

- On page 20, footnote 30 says, "Michigan state Medicaid officials noted that they had access to the full DMF in the past."
- The footnote further says, "Officials from Florida stated that they currently do not use the public DMF because they do not have access to the system and are concerned about the fees that may be required to access it."
- Lastly, beginning on the bottom of page 22 and continuing on page 23, the section referring to States having different methods for identifying deceased providers, we offer the following:

We have never entered into an agreement with the State of Michigan, or any State agency in Michigan, to share our full DMF. However, we do have data sharing agreements with the States—including Michigan—under which we provide death indicators based on our complete (or "full") death data included with all of our State verifications (i.e., State Verification and Exchange System (SVES), and State Online Query (SOLQ) system). Both SVES and SOLQ systems provide the date of death. In addition, the Centers for Medicare and Medicaid Services (CMS) receives the "full DMF" from us on a weekly basis and could share necessary information with the States to ensure proper payment of Medicaid benefits. Thus, State agencies do in fact have access to death information maintained in our full DMF and do not need to enter into separate, reimbursable agreements with us to obtain this data. The report should emphasize that the States already have access to death information maintained in the full DMF through the above-mentioned exchanges and CMS.

In addition, on page 20, footnote 30, says, "However, in the recent past, SSA has restricted access due to new system requirements. Specifically, SSA now requires that states that access the program will not release information on the deceased to third parties." We do not have new systems requirements as referenced on page 20. We believe this statement may be alluding to the statutory restrictions imposed by the Balanced Budget Act of 2013 (Balanced Budget Act), which requires the Department of Commerce to place certain restrictions on recipients of the public DMF, which does not include State death information. The requirements outlined in the Balanced Budget Act are only applicable to the public DMF, and does not affect our sharing of the "full DMF." The Department of Commerce, not SSA, is responsible for overseeing the requirements of the Balanced Budget Act.

If this footnote is referring to our full death data, which the States have access to, we note that there have been no changes in States' ability to re-disclose this information. The Social Security Act prohibits States from re-disclosing the full death file for other purposes. Such re-disclosure restrictions do not limit a State agency from using the death information to ensure the proper payment of a benefit.

# Appendix IV: Comments from the Arizona Health Care Cost Containment System



Douglas A. Ducey, Governor  
Thomas J. Betlach, Director

March 25, 2015

Seto Bagdoyan  
Director, Forensic Audits and Investigative Services  
U.S. Government Accountability Office  
441 G. Street, NW  
Washington, DC 20548

Re: U.S. GAO Report to the Chairman, Committee on Energy and Commerce, House of Representatives; GAO-15-313

Dear Mr. Bagdoyan:

The Arizona Health Care Cost Containment System ("AHCCCS") is Arizona's single state Medicaid agency. AHCCCS has reviewed the U.S. GAO Report to the Chairman, Committee on Energy and Commerce, House of Representatives, GAO-15-313, (hereinafter "GAO Report") and takes exception to being included in a series of findings that offer no state-specific detail, particularly when there is state-specific detail for Arizona that exists to refute many of the global conclusions the GAO reached. AHCCCS is particularly concerned regarding the methodology (aggregated data and the time period) and the audit objectives. The findings contain misstatements that cannot be attributed to either state for the lack of specificity.

This is particularly discouraging for states when as described in the report GAO has based most of their findings in data sources that are considered unreliable. In addition, the findings do not reflect current states processes, as the implementation of the Affordable Care Act provisions commenced later during 2011 and have been under implementation and continuous review by CMS and other federal agencies since its inception. Some of these examples are discussed below.

#### **Beneficiary Controls**

##### **Deceased Beneficiaries**

Arizona has multiple tools to ensure termination of deceased beneficiaries and is concerned that its best practices are being obfuscated in the GAO Report's global presentation. Arizona uses SSA's Wire Third Party Query (WTPY) to obtain date of death information at initial application and renewal. In addition to the WTPY, Arizona eligibility agencies use SSA's real-time SOLQI to obtain date of death information at initial application and renewal. The SSA does, however, notify the State of the date of death for SSI Cash recipients on the daily SDX file. CMS notifies the State of the date of death for individuals receiving Medicare.

Arizona also matches with the Arizona Office of Vital Records death file monthly. Through past experience, The State has found the SSA death file to be inaccurate. By relying on the information from the State's own Office of Vital Records, accuracy in date of death matches is very good. The Arizona Auditor General conducted a data match of all records for deaths registered with Office of Vital Records from July 1, 2008 to April 1, 2009, in comparison to all 1.2 million active AHCCCS members as of March 29, 2009. As a result of this data match, the Auditor General identified 582 deceased AHCCCS members. Upon review of the AHCCCS system, the Auditor General found that AHCCCS had already recognized all but 20 of these individuals as being deceased. These 20 individuals were not identified due to an insignificant weakness in the AHCCCS program matching logic and due to the receipt of incomplete monthly vital record information from the Department of Health Services. AHCCCS and the Department of Health Services have since taken action to correct both of these issues.

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**Social Security Numbers and Identity Verification**

There are numerous factors that can impact beneficiary identity verification. For instance, individuals who are only eligible for emergency services because of their immigration status would not have a valid Social Security Number (SSN). The State sought to verify whether individuals qualifying only for emergency services were included in the review sample as this would skew results. In addition, it is common that beneficiaries use other names or change their name (e.g., marriage), which may result in a mismatch but not in an identity verification error unless a manual review and inquiry is conducted.

For several years now, Arizona has used SSA's Wire Third Party Query (WTPY) to verify the SSN and identity of individuals applying for Medicaid benefits. The WTPY system verifies SSN, identity, dates of death and provides the same level of verification as does use of the SSA index file. In addition to the WTPY, Arizona uses SSA's real-time SOLQI to verify SSN and identity of individuals applying for Medicaid benefits. In cases where the system cannot verify the SSN, state eligibility workers ask additional questions, such as the name on Social Security card or other names used to clear inconsistencies to obtain verification of identity and SSN. The State receives the WTPY and SOLQI at no cost and receives the same information as is contained in the SSA index file and master death file.

**Incarcerated Beneficiaries**

Based on Arizona's experience, the SSA Incarceration file is often out-of-date, requiring manual follow-up with individuals. Accordingly, for several years now, Arizona has conducted electronic matches with the Arizona Department of Corrections and the Arizona Department of Juvenile Corrections. In addition, the State receives daily files electronically from several counties, including the two largest – Maricopa and Pima – as well as rural counties, including Yuma, Coconino, Cochise, Pinal, Yavapai and Mohave. This allows the State to obtain incarceration status from county jails and suspend enrollment of beneficiaries until the State is notified of their release. The State also has manual notification processes in place to identify juveniles in detention in eight out of the 15 counties.

Through this electronic data file transfer, the State cost avoidance in September 2014 for the county jail suspension process alone was \$374,539.

Finally, the GAO Report cites 390 cases where incarcerated individuals received medical services, but fails to distinguish whether those persons were hospitalized. Medicaid reimbursement is proper when an incarcerated individual is hospitalized for over 24 hours. Additionally, these cases could validate the point that the incarceration data source used is not accurate. This is why state and county-level data is critical to optimizing efficiencies in this area.

**Beneficiaries Receiving Benefits in Two or More States**

Arizona uses the PARIS file each quarter to identify beneficiaries who may be residents of another state. Appropriate action is taken to ensure denial of eligibility. In addition, CMS notifies Arizona if another state begins paying a beneficiary's Medicare premiums, allowing Arizona to take appropriate action.

In 2013, Arizona saved \$1.73 million in cost avoidance by ensuring residents of other states were not made eligible for Arizona Medicaid.

**Invalid Beneficiary Addresses**

Arizona validates an applicant's address using USPS software. However, the GAO Report assumes that all physical addresses are known to the U.S. Postal Service (USPS). Certainly, Arizona requires a residential address for all beneficiaries. However, the address does not have to be a valid USPS address. Many AHCCCS beneficiaries are homeless or live in remote rural areas or on American Indian reservations where residents do not have a standard USPS address. AHCCCS has nearly 150,000 American Indian/Alaska Natives enrolled in the program. In cases where the address is not a valid USPS address due to one of the reasons described above, the beneficiary must enter a description of their physical location and a city, state, and ZIP code. AHCCCS does not maintain any blank addresses.

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## Appendix IV: Comments from the Arizona Health Care Cost Containment System

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### Beneficiary Income

Arizona uses The Work Number, but that is not the primary or only source of income data. Arizona uses multiple data sources to verify income. Some of these include The Work Number, Base Wage, State New Hire, Social Security, Unemployment Insurance, and Arizona State Retirement System data. In addition to state retirement and disability payments, the Arizona State Retirement System data includes employment data on over 200,000 employees of the state, counties, municipalities, universities, community colleges, school districts and other political entities who pay into the system. Arizona also identifies Veteran's Administration and Federal Pension income information on the quarterly PARIS file that allows the State to take appropriate when a beneficiary is over income.

Under Arizona's verification plan on file with CMS, the State only accepts the applicant's attestation of income when there is data found in the electronic sources and the applicant's attestation is under the income limit. If there is no data found in the electronic sources, the applicant must provide documentation of their income. If the individual attests to having no income, they must provide information on how they support the household. For applicants approved with no income, electronic data sources are reviewed for six months after approval and at renewal to determine if new income is obtained.

### Provider Fraud Controls

The GAO Report's findings are an extrapolation from the combined set of states' data, making an accurate response very difficult. Arizona questioned the veracity of the data sources as during 2011 several changes at the national level were also occurring. In Arizona's experience, some federal files contain errors and discrepancies or have to be manually vetted because of lack of specific identifiers for purposes of data matching. Arizona's Office of the Inspector General (OIG) has experienced issues when dealing with the exclusion databases and the SSA Death Master File from that time period.

### Provider Registration

Arizona views provider registration as a central component to maintaining program integrity. Accordingly, Arizona requires all providers to enroll with the state Medicaid agency through a central process managed under the AHCCCS OIG. This practice has allowed AHCCCS to implement concrete control systems and monitoring tools ensuring the integrity of the provider network. For instance, Arizona does not activate providers with international addresses, so these issues cannot be attributed to Arizona. Also as part of provider screening, Arizona obtains a monthly file from licensing boards, like the Arizona Medical Board, to obtain information on adverse actions. However, states have little to no ability to obtain that type of data from other state systems.

### Review of AHCCCS Provider Screening Controls

The AHCCCS OIG conducted a special project to determine if the current control system for provider enrollment was effective, and to establish the degree of accuracy of such controls. During 2014, the AHCCCS OIG contracted with Lexis-Nexis to conduct a thorough screening of the provider network including the individuals listed in the disclosures of ownership.

The contractor provided the details of the screening at the end of the CY 2014, and the OIG's Provider Compliance Section had recently verified the findings against internal records. The vendor utilized a series of public databases to conduct their checks. This includes but was not limited to: the GSA sanction file, LEIE, SSA public database, DEA and CLIA.

The report with the initial findings encountered that the provider registration automated checking system in place is efficient; and that out of approximately 60,000 provider records shared, only 331 returned inconclusive results.

Some of the results include expired licenses from other states. This does not on its own imply a situation of risk because the provider may have a current license from Arizona, which would not exclude the provider to participate in the program. Other findings stemmed from cross-references with individuals that may have been related to current providers by business or personal association; however, this is not an indicator, nor a condition, for enrollment or denial of enrollment.

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## Appendix IV: Comments from the Arizona Health Care Cost Containment System

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### AHCCCS Recommendations

Arizona is concerned of the potential adverse consequences of possible erroneous findings or the use of data to attribute errors to all states when each state is unique in its processes. It is challenging to charge states with errors based on issues over which states have little or no control, particularly as it relates to content, accessibility, and matching of federal data. Some opportunities for positive collaboration that could yield improvements in program integrity are below.

#### **Allow states to use disclosures conducted by Medicare or another State Medicaid Program.**

Medicare has similar provider screening requirements to Medicaid, but Medicare does not share data on disclosures with the states. Similarly, states are unable to obtain other state Medicaid disclosures. Sharing this data can create efficiencies and allow better controls for states.

In accordance with the guidance documents and clarification obtained from CMS on several occasions, it appears that the screening process conducted by Medicare and/or Medicaid for the specialized providers could be accepted by another state regarding the enrollment process. States now can waive the site visits and the fees if it has been established that the provider is enrolled with Medicare or with another State Medicaid agency and such screening has occurred during the last 12 months. However, the issue regarding the screening process is not the same as for disclosures, which is contained in a separate set of CMS provisions.

The issue that Arizona faces is that the Disclosure of Ownership and the Disclosure of Persons Convicted of Crimes is not yet part of the screening process that can be waived. AHCCCS believes this should be clarified to address the additional information, such as the background checks or fingerprinting, once those items are implemented. The screening process is already accepted by all states and this discussion point should be modified to reflect that and include the issue related to disclosures.

#### **Allow states to access the federal criminal data base to conduct initial and periodic background checks on providers.**

The AHCCCS OIG recommends CMS work with the FBI to obtain data from the FBI criminal data base. Currently, states must take individual steps to obtain this data but if it could be centralized and easily accessed by states, this will provide a useful tool to assist states in their provider fraud controls.

In accordance with the provisions contained in 42 CFR 455.434, CMS requires the state Medicaid program to “Assure that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.”

According to the CMS informational bulletin issued in 2011, the requirement is not required yet. “Additional sub-regulatory guidance will be issued on criminal background checks and fingerprinting requirements, following which States will have 60 days to implement these enhanced provider screening requirements.”

States would greatly benefit from accessing to the Federal Bureau of Investigation (FBI) Criminal Justice Information Services (CJIS) Division information regarding certification of fingerprints and/or Identity History Summary to conduct initial and periodic background checks for all providers. While Arizona understands the difficulties of such implementation, it is an opportunity for CMS to start conversations and make possible an efficient exchange of information, not on an individual state-by-state basis, but as a data system that can be used by all states to run automated criminal background checks on all providers, similar to the SSA file. The AHCCCS OIG is a criminal justice agency with the authority to conduct investigations and access the ACJIS for case by case reviews.

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**Appendix IV: Comments from the Arizona  
Health Care Cost Containment System**

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**Promote other national initiatives for data sharing on Medicare and provider license verifications.**

The AHCCCS OIG has learned that as efficient as the current provider enrollment processes are, the availability of data maintained by the federal government, such as national incarceration data, national criminal background history, and IRS data, could improve the accuracy of the screening processes as well as avoid loss by fraud, waste or abuse.

In the experience of the AHCCCS OIG, state limitations regarding the provider screening system are related to lack of centralization of federal databases – e.g., PECOS or the exclusion data bases. Other external factors also impede states from verifying real time data against information, such as the SSA or the IRS. At the same time states are attempting to implement greater controls into the provider registration process, access to these federal data bases is becoming more cumbersome. National initiatives for data sharing are needed to prevent bad actors from entering the Medicaid program. A data repository for Medicare, disclosures of providers or a national license verification system, are some options for national tools that states could access to assist them in getting better provider screening controls.

Many of the opportunities to strengthen provider fraud controls require significant investment from states at a time when states like Arizona face serious budget deficits. Nevertheless, the AHCCCS OIG is seeking to incorporate criminal background checks from reliable sources like ACJIS as well as incorporating real time SSA data and USPS for address validation for provider enrollment. Greater state-federal partnerships in this area can help support states and leverage resources to maximize efficiency. In addition, the accessibility of compatible and downloadable systems would reduce the high demand of resources for manual searches and will reduce the response time when screening providers (e.g., PECOS).

Every opportunity to achieve efficiencies in the access to data should be explored and program integrity must be viewed as a state-federal partnership in that regard.

Best Regards,



Monica Higuera Coury  
Assistant Director  
Office of Intergovernmental Relations

# Appendix V: Comments from the Agency for Health Care Administration, State of Florida



RICK SCOTT  
GOVERNOR  
ELIZABETH DUDEK  
SECRETARY

March 25, 2015

Stephen Lord  
Managing Director, Forensic Audits and Investigative Service  
United States Government Accountability Office  
441 G Street, Northwest  
Washington, DC 20548

Dear Mr. Lord,

Thank you for providing the Agency for Health Care Administration (AHCA) with an opportunity to review and comment on the draft report entitled *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*.

While we do not have any comments at this time, we support the Government Accountability Office's (GAO) efforts to identify and improve provider and beneficiary fraud.

Again, thank you for the opportunity to review the report. If you have any questions or need additional information from AHCA, please contact Mary Beth Sheffield, Audit Director, at (850) 412-3978.

Sincerely,

A handwritten signature in blue ink that reads "Elizabeth Dudek".

Elizabeth Dudek  
Secretary

ED/cs

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# Appendix VI: Comments from the Department of Community Health, State of Michigan

Note: Page numbers in the draft report may differ from those in this report.



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

NICK LYON  
DIRECTOR

March 31, 2015

Julia DiPonio, Senior Analyst  
U.S. Government Accountability Office (GAO)  
1999 Bryan Street, Suite 2200  
Dallas, TX 75201-6848

RE: GAO-15-313 Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls

Dear Ms. DiPonio:

Thank you for providing the State of Michigan, Medical Services Administration the opportunity to review and comment on the draft General Accounting Office's report: *Medicaid – Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*. We truly appreciate the ample amount of time allowed to adequately respond to this report.

The State of Michigan agrees with what has been presented in the report, and supports the two executive recommendations to CMS, highlighted on page 28 of the draft report:

- Issue guidance to the states to better identify beneficiaries who are deceased; and
- Provide guidance to states on the availability of automated information through Medicare's enrollment database – the Provider Enrollment, Chain, and Ownership System (PECOS) and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

In support of the first recommendation, additional guidance from CMS on better identifying deceased beneficiaries would be extremely valuable. There were recent negotiations with CMS on the use of the federal death match, and there were changes to the requirements of what is allowed/not allowed with the data. Currently the State of Michigan, Vital Records Division and Office of Legal Affairs, are sorting through those changes and determining how those impact existing processes.

Also, in response to the second recommendation and as noted in the report, Michigan currently uses PECOS for medium-high risk providers, to determine necessity of a site visit; however this process is manual and burdensome. We were unaware of the capability to request monthly automated data extract files from PECOS, and look forward to CMS potentially including ownership information in this file to help us more effectively and efficiently screen providers.

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**Appendix VI: Comments from the Department  
of Community Health, State of Michigan**

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Ms. Julia DiPonio  
March 31, 2015  
Page 2 of 2

We again, would like to thank you for the opportunity to provide comments on your draft report. If you have any questions about our comments or require additional information, please feel free to contact my office at (517) 241-7882.

Sincerely,



Stephen Fitton,  
Medicaid Director

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# Appendix VII: GAO Contact and Staff Acknowledgments

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## GAO Contact

Seto Bagdoyan, (202) 512-6722 or bagdoyans@gao.gov

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## Staff Acknowledgments

In addition to the contact named above, Matthew Valenta (Assistant Director), John Ahern, Mariana Calderón, Melinda Cordero, Julia DiPonio, Lorraine Ettaro, Colin Fallon, Barbara Lewis, Maria McMullen, Kevin Metcalfe, Rubén Montes de Oca, James Murphy, Christine San, Paola Tena, and Carolyn Yocom made key contributions to this report.

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